Washington State Department of Social & Health Services

DDD Division of Developmental Disabilities

DIVISION OF DEVELOPMENTAL DISABILITIES (DDD)

VOLUNTARY HCBS WAIVER PARTICIPATION

CLIENT NAME (PRINT)	DDD NUMBER

You are being considered for service under the _____ Waiver. This Waiver is authorized under Title XIX of the Social Security Act to provide home and community-based care for eligible individuals.

I have been informed of my alternatives and choose to receive service under a DDD HCBS Waiver.

CLIENT'S SIGNATURE	DATE
LEGAL REPRESENTATIVE'S SIGNATURE	DATE

I have been informed of my alternatives and choose to receive institutional services.

CLIENT'S SIGNATURE	DATE
LEGAL REPRESENTATIVE'S SIGNATURE	DATE

cc: Client or Legal Representative
Client File